

## APPENDIX B

### MDS and QUARTERLY REVIEW FORMS FOR VERSION 2.0

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## SECTION AA. IDENTIFICATION INFORMATION

## GENERAL INSTRUCTIONS

**Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)**

☐ = When box blank, must enter number or letter    ☐ = When letter in box, check if modification applies

# **MINIMUM DATA SET (MDS) — VERSION 2.0** **FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING**

## **BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION**

### SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>	
2. ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	
3. LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	
4. ZIP CODE OF PRIOR PRIMARY RESIDENCE	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) Prior stay at this nursing home Stay in other nursing home Other residential facility—board and care home, assisted living, group home MH/psychiatric setting MR/DD setting NONE OF ABOVE	
6. LIFETIME OCCUPATION(S)	Put "I" between two occupations <div style="display: flex; justify-content: space-between;"> <div style="width: 45%; border: 1px solid black; height: 20px;"></div> <div style="width: 45%; border: 1px solid black; height: 20px;"></div> </div>	
7. EDUCATION (Highest Level Completed)	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           1. No schooling            2. 8th grade/less            3. 9-11 grades            4. High school         </div> <div style="width: 45%;">           5. Technical or trade school            6. Some college            7. Bachelor's degree            8. Graduate degree         </div> </div>	
8. LANGUAGE	(Code for correct response) a. Primary Language 0. English    1. Spanish    2. French    3. Other b. If other, specify	
9. MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes	
10. CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition	
11. DATE BACKGROUND INFORMATION COMPLETED	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>	

### SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)	(Check all that apply. If all information UNKNOWN, check last box only) <b>CYCLE OF DAILY EVENTS</b> Stays up late at night (e.g., after 9 pm) Naps regularly during day (at least 1 hour) Goes out 1+ days a week Stays busy with hobbies, reading, or fixed daily routine Spends most of time alone or watching TV Moves independently indoors (with appliances, if used) Use of tobacco products at least daily NONE OF ABOVE	
	<b>EATING PATTERNS</b> Distinct food preferences Eats between meals all or most days Use of alcoholic beverage(s) at least weekly NONE OF ABOVE	
	<b>ADL PATTERNS</b> In bedclothes much of day Wakens to toilet all or most nights Has irregular bowel movement pattern Showers for bathing Bathing in PM NONE OF ABOVE	
	<b>INVOLVEMENT PATTERNS</b> Daily contact with relatives/close friends Usually attends church, temple, synagogue (etc.) Finds strength in faith Daily animal companion/presence Involved in group activities NONE OF ABOVE UNKNOWN—Resident/family unable to provide information	

### SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signatures	Title	Sections	Date
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

**MINIMUM DATA SET (MDS) — VERSION 2.0**  
**FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING**  
**FULL ASSESSMENT FORM**  
 (Status in last 7 days, unless other time frame indicated)

**SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION**

1. RESIDENT NAME	a. (First) _____ b. (Middle Initial) _____ c. (Last) _____ d. (Jr/Sr) _____			
2. ROOM NUMBER	_____			
3. ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period _____ — _____ — _____ Month Day Year b. Original (0) or corrected copy of form (enter number of correction) _____			
4a. DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) _____ — _____ — _____ Month Day Year			
5. MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			
6. MEDICAL RECORD NO.	_____			
7. CURRENT PAYMENT SOURCES FOR N.H. STAY	(Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem _____ VA per diem _____ Medicare per diem _____ Self or family pays for full per diem _____ Medicare ancillary part A _____ Medicaid resident liability or Medicare co-payment _____ Medicare ancillary part B _____ Private insurance per diem (including co-payment) _____ CHAMPUS per diem _____ Other per diem _____			
8. REASONS FOR ASSESSMENT	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment			
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Legal guardian _____ Durable power attorney/financial _____ Other legal oversight _____ Family member responsible _____ Durable power of attorney/health care _____ Patient responsible for self _____ NONE OF ABOVE _____			
10. ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will _____ Feeding restrictions _____ Do not resuscitate _____ Medication restrictions _____ Do not hospitalize _____ Other treatment restrictions _____ Organ donation _____ Autopsy request _____ NONE OF ABOVE _____			

**SECTION B. COGNITIVE PATTERNS**

1. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)
2. MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem

3. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season _____ a. _____ Location of own room _____ b. _____ That he/she is in a nursing home Staff names/faces _____ c. _____ NONE OF ABOVE are recalled d. _____
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions
5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6. CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING	(With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used _____ a. _____ Hearing aid, present and not used regularly _____ b. _____ Other receptive comm. techniques used (e.g., lip reading) _____ c. _____ NONE OF ABOVE _____ d. _____
3. MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech _____ a. _____ Signs/gestures/sounds _____ d. _____ Writing messages to express or clarify needs _____ b. _____ Communication board _____ e. _____ American sign language or Braille _____ c. _____ Other _____ f. _____ NONE OF ABOVE _____ g. _____
4. MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
5. SPEECH CLARITY	(Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words
6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
7. CHANGE IN COMMUNICATION/HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

## SECTION D. VISION PATTERNS

1. VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2. VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of the following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a. b. c.
3. VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

## SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)  VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack  h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues  SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern  SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking  LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction	
2. MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3. CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4. BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily  (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered  a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	(A) (B)

5. CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated
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## SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities NONE OF ABOVE	a. b. c. d. e. f. g.
2. UNSETTLED RELATIONSHIPS	Cover/open conflict with or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/anger with family/friends Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines NONE OF ABOVE	a. b. c. d. e. f. g. h.
3. PAST ROLES	Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community NONE OF ABOVE	a. b. c. d.

## SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	(A) (B)
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days	SELF-PERF SUPPORT
a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c. WALK IN ROOM	How resident walks between locations in his/her room	
d. WALK IN CORRIDOR	How resident walks in corridor on unit	
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f. LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g. DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h. EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
i. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	
j. PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	

2.	<b>BATHING</b>	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <i>Code for most dependent in self-performance and support.</i> (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above)		
3.	<b>TEST FOR BALANCE</b> (see training manual)	(Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	<b>FUNCTIONAL LIMITATION IN RANGE OF MOTION</b> (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—including shoulder or elbow		
		c. Hand—including wrist or fingers		
		d. Leg—including hip or knee		
		e. Foot—including ankle or toes		
		f. Other limitation or loss		
5.	<b>MODES OF LOCOMOTION</b>	(Check all that apply during last 7 days) Cane/walker/crutch Wheeled self Other person wheeled	a.	b.
		Wheelchair primary mode of locomotion		
		NONE OF ABOVE		
6.	<b>MODES OF TRANSFER</b>	(Check all that apply during last 7 days) Bedfast all or most of time Bed rails used for bed mobility or transfer Lifted manually	a.	b.
		Lifted mechanically		
		Transfer aid (e.g., slide board, trapeze, cane, walker, brace)		
		NONE OF ABOVE		
	<b>TASK SEGMENTATION</b>	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes		
8.	<b>ADL FUNCTIONAL REHABILITATION POTENTIAL</b>	Resident believes he/she is capable of increased independence in at least some ADLs Direct care staff believe resident is capable of increased independence in at least some ADLs Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE	a.	b.
9.	<b>CHANGE IN ADL FUNCTION</b>	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

**SECTION H. CONTINENCE IN LAST 14 DAYS**

1.	<b>CONTINENCE SELF-CONTROL CATEGORIES</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS)
	0. CONTINENT—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]
	1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
	2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
	3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
	4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
a.	<b>BOWEL CONTINENCE</b> Control of bowel movement, with appliance or bowel continence programs, if employed
	<b>BLADDER CONTINENCE</b> Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed
2.	<b>BOWEL ELIMINATION PATTERN</b> Bowel elimination pattern regular—at least one movement every three days Constipation
	a. Diarrhea
	b. Fecal impaction
	c. NONE OF ABOVE

3.	<b>APPLIANCES AND PROGRAMS</b>	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter	a.	b.	c.	d.	e.
		Did not use toilet room/commode/urinal Pads/briefs used Enemas/irrigation Ostomy present NONE OF ABOVE					
4.	<b>CHANGE IN URINARY CONTINENCE</b>	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated					

**SECTION I. DISEASE DIAGNOSES**

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	<b>DISEASES</b> (If none apply, CHECK the NONE OF ABOVE box)																																											
	ENDOCRINE/METABOLIC/ NUTRITIONAL Diabetes mellitus Hyperthyroidism Hypothyroidism HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease MUSCULOSKELETAL Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture NEUROLOGICAL Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease																																											
	Hemiplegia/Hemiparesis Multiple sclerosis Paraplegia Parkinson's disease Quadriplegia Seizure disorder Transient ischemic attack (TIA) Traumatic brain injury PSYCHIATRIC/MOOD Anxiety disorder Depression Manic depression (bipolar disease) Schizophrenia PULMONARY Asthma Emphysema/COPD SENSORY Cataracts Diabetic retinopathy Glaucoma Macular degeneration OTHER Allergies Anemia Cancer Renal failure NONE OF ABOVE																																											
	a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.	t.	u.	v.	w.	x.	y.	z.	aa.	bb.	cc.	dd.	ee.	ff.	gg.	hh.	ii.	jj.	kk.	ll.	mm.	nn.	oo.	pp.	qq.	rr.
2.	<b>INFECTIONS</b> (If none apply, CHECK the NONE OF ABOVE box)																																											
	Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection																																											
	Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE																																											
	a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.																															
3.	<b>OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES</b>																																											
	a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.	t.	u.	v.	w.	x.	y.	z.	aa.	bb.	cc.	dd.	ee.	ff.	gg.	hh.	ii.	jj.	kk.	ll.	mm.	nn.	oo.	pp.	qq.	rr.

**SECTION J. HEALTH CONDITIONS**

1.	<b>PROBLEM CONDITIONS</b> (Check all problems present in last 7 days unless other time frame is indicated)															
	INDICATORS OF FLUID STATUS Weight gain or loss of 3 or more pounds within a 7 day period Inability to lie flat due to shortness of breath Dehydrated; output exceeds input Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days OTHER															
	Dizziness/Vertigo Edema Fever Hallucinations Internal bleeding Recurrent lung aspirations in last 90 days Shortness of breath Syncope (fainting) Unsteady gait Vomiting NONE OF ABOVE															
	a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.

2.	<b>PAIN SYMPTOMS</b>	(Code the highest level of pain present in the last 7 days)	
	a. FREQUENCY with which resident complains or shows evidence of pain		b. INTENSITY of pain
	0. No pain (skip to J4)		1. Mild pain
	1. Pain less than daily		2. Moderate pain
	2. Pain daily		3. Times when pain is horrible or excruciating
3.	<b>PAIN SITE</b>	(If pain present, check all sites that apply in last 7 days)	
	Back pain	a.	Incisional pain
	Bone pain	b.	Joint pain (other than hip)
	Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)
	Headache	d.	Stomach pain
	Hip pain	e.	Other
4.	<b>ACCIDENTS</b>	(Check all that apply)	
	Fell in past 30 days	a.	Hip fracture in last 180 days
	Fell in past 31-180 days	b.	Other fracture in last 180 days
			NONE OF ABOVE
5.	<b>STABILITY OF CONDITIONS</b>	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)	
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	
		End-stage disease, 6 or fewer months to live	
		NONE OF ABOVE	

## SECTION K. ORAL/NUTRITIONAL STATUS

1.	<b>ORAL PROBLEMS</b>	Chewing problem	
		Swallowing problem	
		Mouth pain	
		NONE OF ABOVE	
2.	<b>HEIGHT AND WEIGHT</b>	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes	
		a. HT (in.)	b. WT (lb.)
3.	<b>WEIGHT CHANGE</b>	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days	
		0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days	
		0. No 1. Yes	
4.	<b>NUTRITIONAL PROBLEMS</b>	Complains about the taste of many foods	
		a.	Leaves 25% or more of food uneaten at most meals
		b.	NONE OF ABOVE
5.	<b>NUTRITIONAL APPROACHES</b>	(Check all that apply in last 7 days)	
	Parenteral/IV	a.	Dietary supplement between meals
	Feeding tube	b.	Plate guard, stabilized built-up utensil, etc.
	Mechanically altered diet	c.	On a planned weight change program
	Syringe (oral feeding)	d.	
	Therapeutic diet	e.	
			NONE OF ABOVE
6.	<b>PARENTERAL OR ENTERAL INTAKE</b>	(Skip to Section L if neither 5a nor 5b is checked)	
	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days		
	0. None 3. 51% to 75%		
	1. 1% to 25% 4. 76% to 100%		
	2. 26% to 50%		
	b. Code the average fluid intake per day by IV or tube in last 7 days		
	0. None 3. 1001 to 1500 cc/day		
	1. 1 to 500 cc/day 4. 1501 to 2000 cc/day		
	2. 501 to 1000 cc/day 5. 2001 or more cc/day		

## SECTION L. ORAL/DENTAL STATUS

1.	<b>ORAL STATUS AND DISEASE PREVENTION</b>	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	
		Has dentures or removable bridge	
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	
		Broken, loose, or carious teeth	
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	
		NONE OF ABOVE	

## SECTION M. SKIN CONDITION

1.	<b>ULCERS</b>	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	
	(Due to any cause)		
	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
	b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		
	c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.		
	d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.		
2.	<b>TYPE OF ULCER</b>	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
	a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue		
	b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
3.	<b>HISTORY OF RESOLVED ULCERS</b>	Resident had an ulcer that was resolved or cured in LAST 90 DAYS	
		0. No 1. Yes	
4.	<b>OTHER SKIN PROBLEMS OR LESIONS PRESENT</b>	(Check all that apply during last 7 days)	
		Abrasions, bruises	
		Burns (second or third degree)	
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	
		Skin desensitized to pain or pressure	
		Skin tears or cuts (other than surgery)	
		Surgical wounds	
		NONE OF ABOVE	
5.	<b>SKIN TREATMENTS</b>	(Check all that apply during last 7 days)	
		Pressure relieving device(s) for chair	
		Pressure relieving device(s) for bed	
		Turning/repositioning program	
		Nutrition or hydration intervention to manage skin problems	
		Ulcer care	
		Surgical wound care	
		Application of dressings (with or without topical medications) other than to feet	
		Application of ointments/medications (other than to feet)	
		Other preventative or protective skin care (other than to feet)	
		NONE OF ABOVE	
6.	<b>FOOT PROBLEMS AND CARE</b>	(Check all that apply during last 7 days)	
		Resident has one or more foot problems—e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems	
		Infection of the foot—e.g., cellulitis, purulent drainage	
		Open lesions on the foot	
		Nails/calluses trimmed during last 90 days	
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	
		Application of dressings (with or without topical medications)	
		NONE OF ABOVE	

## SECTION N. ACTIVITY PURSUIT PATTERNS

1.	<b>TIME AWAKE</b>	(Check appropriate time periods over last 7 days)	
		Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning	Evening
		a.	b.
		Afternoon	NONE OF ABOVE
		c.	d.
(If resident is comatose, skip to Section O)			
2.	<b>AVERAGE TIME INVOLVED IN ACTIVITIES</b>	(When awake and not receiving treatments or ADL care)	
		0. Most—more than 2/3 of time 2. Little—less than 1/3 of time	
		1. Some—from 1/3 to 2/3 of time 3. None	
3.	<b>PREFERRED ACTIVITY SETTINGS</b>	(Check all settings in which activities are preferred)	
		Own room	
		a.	Outside facility
		b.	
		c.	NONE OF ABOVE
4.	<b>GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)</b>	(Check all PREFERENCES whether or not activity is currently available to resident)	
		Cards/other games	
		a.	Trips/shopping
		b.	Walking/wheeling outdoors
		c.	Watching TV
		d.	Gardening or plants
		e.	Talking or conversing
		f.	Helping others
			NONE OF ABOVE
			m.

Resident \_\_\_\_\_

Numeric Identifier \_\_\_\_\_

5. PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines		
	0. No change	1. Slight change	2. Major change
	a. Type of activities in which resident is currently involved		
	b. Extent of resident involvement in activities		

## SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)		
2. NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No      1. Yes		
3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)		
4. DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)		
	a. Antipsychotic		d. Hypnotic
	b. Anxiolytic		e. Diuretic
	c. Antidepressant		

## SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days			
	TREATMENTS		PROGRAMS	
	Chemotherapy	a.	Ventilator or respirator	
	Dialysis	b.	Alcohol/drug treatment program	
	IV medication	c.	Alzheimer's/dementia special care unit	
	Intake/output	d.	Hospice care	
	Monitoring acute medical condition	e.	Pediatric unit	
	Ostomy care	f.	Respite care	
	Oxygen therapy	g.	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	
	Radiation	h.	NONE OF ABOVE	
b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note—count only post admission therapies]				
(A) = # of days administered for 15 minutes or more      DAYS      MIN				
(B) = total # of minutes provided in last 7 days      (A)      (B)				
	a. Speech - language pathology and audiology services			
	b. Occupational therapy			
	c. Physical therapy			
	d. Respiratory therapy			
	e. Psychological therapy (by any licensed mental health professional)			
2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received)			
	Special behavior symptom evaluation program			a.
	Evaluation by a licensed mental health specialist in last 90 days			b.
	Group therapy			c.
	Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage			d.
	Reorientation—e.g., cueing			e.
NONE OF ABOVE				
3. NURSING REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily)			
	a. Range of motion (passive)		f. Walking	
	b. Range of motion (active)		g. Dressing or grooming	
	c. Splint or brace assistance		h. Eating or swallowing	
	TRAINING AND SKILL PRACTICE IN:			
	d. Bed mobility		i. Amputation/prosthesis care	
	e. Transfer		j. Communication	
			k. Other	

4. DEVICES AND RESTRAINTS	(Use the following codes for last 7 days:)		
	0. Not used		
	1. Used less than daily		
	2. Used daily		
	Bed rails		
	a. — Full bed rails on all open sides of bed		
	b. — Other types of side rails used (e.g., half rail, one side)		
	c. Trunk restraint		
	d. Limb restraint		
	e. Chair prevents rising		
5. HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)		
6. EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)		
7. PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)		
8. PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)		
9. ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)?		
	0. No      1. Yes		

## SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community		
	0. No      1. Yes		
	b. Resident has a support person who is positive towards discharge		
	0. No      1. Yes		
	c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death)		
	0. No      1. Within 30 days      2. Within 31-90 days      3. Discharge status uncertain		
2. OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)		
	0. No change      1. Improved—receives fewer supports, needs less restrictive level of care      2. Deteriorated—receives more support		

## SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes
	b. Family:	0. No	1. Yes      2. No family
	c. Significant other:	0. No	1. Yes      2. None
2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
Month      Day      Year			
c. Other Signatures      Title      Sections      Date			
d.      Date			
e.      Date			
f.      Date			
g.      Date			
h.      Date			



## SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident received during the last 7 days. Include scheduled medications that are used regularly, but less than weekly .

1. Medication Name and Dose Ordered. Record the name of the medication and dose ordered.
2. Route of Administration (RA). Code the Route of Administration using the following list:

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		
3. Frequency. Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily	QO=every other day
1H=(QH) every hour	(includes every 12 hrs)	4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other
4. Amount Administered (AA). Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. PRN-number of days (PRN-n). If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. NDC Codes. Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

[illegible]

## MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier \_\_\_\_\_

A1.	RESIDENT NAME	a. (First) _____ b. (Middle Initial) _____ c. (Last) _____ d. (Jr/Sr) _____
A2.	ROOM NUMBER	_____
7.	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period <div style="display: flex; justify-content: space-around;"> <div>____</div> <div>____</div> <div>____</div> </div> Month Day Year b. Original (0) or corrected copy of form (enter number of correction) _____
A4a	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) <div style="display: flex; justify-content: space-around;"> <div>____</div> <div>____</div> <div>____</div> </div> Month Day Year
A6.	MEDICAL RECORD NO.	_____
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No _____ 1. Yes _____ (Skip to Section G)
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK _____ 1. Memory problem _____ b. Long-term memory OK—seems/appears to recall long past 0. Memory OK _____ 1. Memory problem _____
B4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions
B5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
C4.	MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
C6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)	VERBAL EXPRESSIONS OF DISTRESS f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction
E2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators present _____ 1. Indicators present, easily altered _____ 2. Indicators present, not easily altered _____	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	(A) (B)
G1.	(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 5. ACTIVITY DID NOT OCCUR during entire 7 days (A)	
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	WALK IN ROOM	How resident walks between locations in his/her room.	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

I.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
J.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <i>Code for most dependent in self-performance.</i> (A) BATHING SELF PERFORMANCE codes appear below		(A)
		0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days		
G4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 1. Limitation on one side 2. Limitation on both sides a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss		(A) (B)
G6.	MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time Bed rails used for bed mobility or transfer NONE OF ABOVE		
H1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS)	0. CONTINENT—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool] 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
	a. BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
	b. BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d.	NONE OF ABOVE
H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Indwelling catheter
		Bladder retraining program	b.	Ostomy present
		External (condom) catheter	c.	NONE OF ABOVE
I2.	INFECTIONS	Urinary tract infection in last 30 days	j.	NONE OF ABOVE
I3.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)		
J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days) Dehydrated; output exceeds input		
		c.	Hallucinations	
			NONE OF ABOVE	
J2.	PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating		
J4.	ACCIDENTS	(Check all that apply) Fell in past 30 days Fell in past 31-180 days		
		a.	Hip fracture in last 180 days	
		b.	Other fracture in last 180 days	
			NONE OF ABOVE	

J5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE	a. b. c. d.
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
K5.	NUTRITIONAL APPROACHES	Feeding tube On a planned weight change program NONE OF ABOVE	b. h. f.
M1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awakes all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE	c. d.
(If resident is comatose, skip to Section O)			
N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	
O1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Anxiolytic c. Antidepressant d. Hypnotic e. Diuretic	
P4.	DEVICES AND RESTRAINTS	Use the following codes for last 7 days: 0. Not used 1. Used less than daily 2. Used daily Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising	
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	
R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
Month Day Year			
c. Other Signatures Title Sections Date			
d. Date			
e. Date			
f. Date			
g. Date			

**MDS QUARTERLY ASSESSMENT FORM**  
(OPTIONAL VERSION FOR RUG III)

Numeric Identifier \_\_\_\_\_

A1.	RESIDENT NAME	<div style="display: flex; justify-content: space-between;"> <div>a. (First)</div> <div>b. (Middle Initial)</div> <div>c. (Last)</div> <div>d. (Jr/Sr)</div> </div>			
	ROOM NUMBER	<div style="display: flex; justify-content: space-between;"> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> </div>			
	ASSESSMENT REFERENCE DATE	<div style="display: flex; justify-content: space-between;"> <div>a. Last day of MDS observation period</div> </div> <div style="display: flex; justify-content: space-between;"> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div style="display: flex; justify-content: space-between;"> <div>b. Original (0) or corrected copy of form (enter number of correction)</div> </div>			
A4.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) <div style="display: flex; justify-content: space-between;"> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> </div> <div style="display: flex; justify-content: space-between;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>			
A6.	MEDICAL RECORD NO.	<div style="display: flex; justify-content: space-between;"> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> <div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div> </div>			
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No                      1. Yes (Skip to Section G)			
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK                      1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK                      1. Memory problem			
B3.	MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season                      a. <div style="border: 1px solid black; width: 20px; height: 20px;"></div> That he/she is in a nursing home Location of own room                      b. <div style="border: 1px solid black; width: 20px; height: 20px;"></div> Staff names/faces                      c. <div style="border: 1px solid black; width: 20px; height: 20px;"></div> NONE OF ABOVE are recalled d. <div style="border: 1px solid black; width: 20px; height: 20px;"></div> e. <div style="border: 1px solid black; width: 20px; height: 20px;"></div>			
B4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions			
	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)			
C4.	MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD			
C6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS			
	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)			

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction
E2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators                      1. Indicators present, easily altered                      2. Indicators present, not easily altered	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feeces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	
G1.	(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR— More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	
	(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days	
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	SELF-PERF
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	SUPPORT

Resident

Numeric Identifier

G1.		(A) (B)	
c.	WALK IN ROOM	How resident walks between locations in his/her room	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit	
	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days	
G3.	TEST FOR BALANCE	(Code for ability during test in the last 7 days)	
	(see training manual)	0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control	
	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 0. No loss 1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss	
G6.	MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time a. NONE OF ABOVE Bed rails used for bed mobility or transfer b.	
G7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes	
H1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS)		
	0. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)		
	1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly		
	2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week		
	3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week		
	4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed	
H2.	BOWEL ELIMINATION PATTERN	Diarrhea c. NONE OF ABOVE Fecal impaction d.	

H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan a.	Indwelling catheter d.
		Bladder retraining program b.	Ostomy present l.
		External (condom) catheter c.	NONE OF ABOVE j.
Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)			
I1.	DISEASES	(If none apply, CHECK the NONE OF ABOVE box)	
	MUSCULOSKELETAL	Multiple sclerosis w.	
	Hip fracture m.	Quadriplegia z.	
	NEUROLOGICAL	PSYCHIATRIC/MOOD	
	Aphasia r.	Depression ee.	
	Cerebral palsy s.	Manic depressive (bipolar disease) ff.	
	Cerebrovascular accident (stroke) t.	OTHER	
	Hemiplegia/Hemiparesis v.	NONE OF ABOVE rr.	
I2.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box)	
	Antibiotic resistant infection (e.g., Methicillin resistant staph) a.	Septicemia g.	
	Clostridium difficile (c. diff.) b.	Sexually transmitted diseases h.	
	Conjunctivitis c.	Tuberculosis l.	
	HIV infection d.	Urinary tract infection in last 30 days j.	
	Pneumonia e.	Viral hepatitis k.	
	Respiratory infection f.	Wound infection l.	
		NONE OF ABOVE m.	
I3.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)	
	a.		
	b.		
J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)	
	INDICATORS OF FLUID STATUS	OTHER	
	Weight gain or loss of 3 or more pounds within a 7 day period a.	Delusions e.	
	Inability to lie flat due to shortness of breath b.	Edema g.	
	Dehydrated; output exceeds input c.	Fever h.	
	Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days d.	Hallucinations i.	
		Internal bleeding j.	
		Recurrent lung aspirations in last 90 days k.	
		Shortness of breath l.	
		Unsteady gait n.	
		Vomiting o.	
		NONE OF ABOVE p.	
J2.	PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days)	
	a. FREQUENCY with which resident complains or shows evidence of pain	b. INTENSITY of pain	
	0. No pain (skip to J4)	1. Mild pain	
	1. Pain less than daily	2. Moderate pain	
	2. Pain daily	3. Times when pain is horrible or excruciating	
J4.	ACCIDENTS	(Check all that apply)	
	Fell in past 30 days a.	Hip fracture in last 180 days c.	
	Fell in past 31-180 days b.	Other fracture in last 180 days d.	
		NONE OF ABOVE e.	
J5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE	
K1.	ORAL PROBLEMS	Chewing problem Swallowing problem NONE OF ABOVE	
K2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes a. HT (in.) b. WT (lb.)	
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	

K5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days)	
	Parenteral/IV	a. <input type="checkbox"/> On a planned weight change program	h. <input type="checkbox"/>
	Feeding tube	b. <input type="checkbox"/> NONE OF ABOVE	i. <input type="checkbox"/>
M.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
	b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.		
	c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.		
	d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.		
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
	a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue		
	b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
M4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days)	
	Abrasions, bruises	a. <input type="checkbox"/>	
	Burns (second or third degree)	b. <input type="checkbox"/>	
	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c. <input type="checkbox"/>	
	Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d. <input type="checkbox"/>	
	Skin desensitized to pain or pressure	e. <input type="checkbox"/>	
	Skin tears or cuts (other than surgery)	f. <input type="checkbox"/>	
	Surgical wounds	g. <input type="checkbox"/>	
	NONE OF ABOVE	h. <input type="checkbox"/>	
M5.	SKIN TREATMENTS	(Check all that apply during last 7 days)	
	Pressure relieving device(s) for chair	a. <input type="checkbox"/>	
	Pressure relieving device(s) for bed	b. <input type="checkbox"/>	
	Turning/repositioning program	c. <input type="checkbox"/>	
	Nutrition or hydration intervention to manage skin problems	d. <input type="checkbox"/>	
	Ulcer care	e. <input type="checkbox"/>	
	Surgical wound care	f. <input type="checkbox"/>	
	Application of dressings (with or without topical medications) other than to feet	g. <input type="checkbox"/>	
	Application of ointments/medications (other than to feet)	h. <input type="checkbox"/>	
	Other preventative or protective skin care (other than to feet)	i. <input type="checkbox"/>	
	NONE OF ABOVE	j. <input type="checkbox"/>	
M6.	FOOT PROBLEMS AND CARE	(Check all that apply during last 7 days)	
	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a. <input type="checkbox"/>	
	Infection of the foot—e.g., cellulitis, purulent drainage	b. <input type="checkbox"/>	
	Open lesions on the foot	c. <input type="checkbox"/>	
	Nails/calluses trimmed during last 90 days	d. <input type="checkbox"/>	
	Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e. <input type="checkbox"/>	
	Application of dressings (with or without topical medications)	f. <input type="checkbox"/>	
	NONE OF ABOVE	g. <input type="checkbox"/>	
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days)	
	Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:		
	Morning	a. <input type="checkbox"/> Evening	c. <input type="checkbox"/>
	Afternoon	b. <input type="checkbox"/> NONE OF ABOVE	d. <input type="checkbox"/>
(If resident is comatose, skip to Section O)			
N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care)	
	0. Most—more than 2/3 of time	2. Little—less than 1/3 of time	
	1. Some—from 1/3 to 2/3 of time	3. None	
O1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
O3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	
	a. Antipsychotic	d. Hypnotic	
	b. Anxiolytic	e. Diuretic	
	c. Antidepressant		

P1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days	
	TREATMENTS		
	Chemotherapy	a. <input type="checkbox"/>	Ventilator or respirator
	Dialysis	b. <input type="checkbox"/>	PROGRAMS
	IV medication	c. <input type="checkbox"/>	Alcohol/drug treatment program
	Intake/output	d. <input type="checkbox"/>	Alzheimer's/dementia special care unit
	Monitoring acute medical condition	e. <input type="checkbox"/>	Hospice care
	Ostomy care	f. <input type="checkbox"/>	Pediatric unit
	Oxygen therapy	g. <input type="checkbox"/>	Respite care
	Radiation	h. <input type="checkbox"/>	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
	Suctioning	i. <input type="checkbox"/>	
	Tracheostomy care	j. <input type="checkbox"/>	
	Transfusions	k. <input type="checkbox"/>	NONE OF ABOVE
	b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)		
	[Note—count only post admission therapies]		
	(A) = # of days administered for 15 minutes or more	DAYS (A)	MIN (B)
	(B) = total # of minutes provided in last 7 days		
	a. Speech - language pathology and audiology services		
	b. Occupational therapy		
	c. Physical therapy		
	d. Respiratory therapy		
	e. Psychological therapy (by any licensed mental health professional)		
P3.	NURSING REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily)	
	a. Range of motion (passive)	f. Walking	
	b. Range of motion (active)	g. Dressing or grooming	
	c. Splint or brace assistance	h. Eating or swallowing	
	TRAINING AND SKILL PRACTICE IN:	i. Amputation/prosthesis care	
	d. Bed mobility	j. Communication	
	e. Transfer	k. Other	
P4.	DEVICES AND RESTRAINTS	Use the following codes for last 7 days:	
	0. Not used		
	1. Used less than daily		
	2. Used daily		
	Bed rails		
	a. — Full bed rails on all open sides of bed		
	b. — Other types of side rails used (e.g., half rail, one side)		
	c. Trunk restraint		
	d. Limb restraint		
	e. Chair prevents rising		
P7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)	
P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)	
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)	
	0. No change	1. Improved—receives fewer supports, needs less restrictive level of care	2. Deteriorated—receives more support
R2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:		
	a. Signature of RN Assessment Coordinator (sign on above line)		
	b. Date RN Assessment Coordinator signed as complete		
	Month	Day	Year
	c. Other Signatures	Title	Sections
	d.		Date
	e.		Date
	f.		Date
	g.		Date
	h.		Date



**MDS QUARTERLY ASSESSMENT FORM**  
(OPTIONAL VERSION FOR RUG-III 1997 Update)

Numeric Identifier \_\_\_\_\_

A1.	RESIDENT NAME				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
A2.	ROOM NUMBER				
	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period ____ - ____ - ____ Month Day Year b. Original (0) or corrected copy of form (enter number of correction)			
A4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) ____ - ____ - ____ Month Day Year			
A6.	MEDICAL RECORD NO.				
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)			
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem			
B3.	MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season a. ____ That he/she is in a nursing home Location of own room b. ____ Staff names/faces c. ____ NONE OF ABOVE are recalled			
B4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions			
	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)			
C4.	MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD			
C6.	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS			
	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)			

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction
E2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators present, easily altered 1. Indicators present, not easily altered	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)	
G1.	(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight—OR—Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	
	(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days	
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	SELF-PERF SUPPORT
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	

G1.		(A)	(B)
c.	<b>WALK IN ROOM</b>	How resident walks between locations in his/her room	
d.	<b>WALK IN HALL</b>	How resident walks in corridor on unit	
e.	<b>LOCOMOTION ON UNIT</b>	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	<b>LOCOMOTION OFF UNIT</b>	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	<b>DRESSING</b>	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	<b>EATING</b>	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
i.	<b>TOILET USE</b>	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	
j.	<b>PERSONAL HYGIENE</b>	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	
G2.	<b>BATHING</b>	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair). Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below	(A)
		0. Independent—No help provided	
		1. Supervision—Oversight help only	
		2. Physical help limited to transfer only	
		3. Physical help in part of bathing activity	
		4. Total dependence	
		5. Activity itself did not occur during entire 7 days	
G3.	<b>TEST FOR BALANCE</b>	(Code for ability during test in the last 7 days)	
		0. Maintained position as required in test	
		1. Unsteady, but able to rebalance self without physical support	
		2. Partial physical support during test; or stands (sits) but does not follow directions for test	
		3. Not able to attempt test without physical help	
		a. Balance while standing	
		b. Balance while sitting—position, trunk control	
<b>FUNCTIONAL LIMITATION IN RANGE OF MOTION</b>		(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT	(A) (B)
		0. No limitation	
		1. Limitation on one side	
		2. Limitation on both sides	
		a. Neck	
		b. Arm—including shoulder or elbow	
		c. Hand—including wrist or fingers	
		d. Leg—including hip or knee	
		e. Foot—including ankle or toes	
		f. Other limitation or loss	
G6.	<b>MODES OF TRANSFER</b>	(Check all that apply during last 7 days)	
		Bedfast all or most of time	a. NONE OF ABOVE
		Bed rails used for bed mobility or transfer	b.
G7.	<b>TASK SEGMENTATION</b>	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them	
		0. No	1. Yes
H1.	<b>CONTINENCE SELF-CONTROL CATEGORIES</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS)		
0. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)			
1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly			
2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week			
3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week			
4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time			
a.	<b>BOWEL CONTINENCE</b>	Control of bowel movement, with appliance or bowel continence programs, if employed	
	<b>BLADDER CONTINENCE</b>	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed	
H2.	<b>BOWEL ELIMINATION PATTERN</b>	Diarhea	c. NONE OF ABOVE
		Fecal impaction	d.

H3. APPLIANCES AND PROGRAMS		Any scheduled toileting plan	a.	Indwelling catheter	d.
		Bladder retraining program	b.	Ostomy present	e.
		External (condom) catheter	c.	NONE OF ABOVE	f.
Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)					
I1.	<b>DISEASES</b>	(If none apply, CHECK the NONE OF ABOVE box)			
		ENDOCRINE/METABOLIC/NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Diabetes mellitus	a.	Multiple sclerosis	w.
		MUSCULOSKELETAL		Quadruplegia	z.
		Hip fracture	m.	PSYCHIATRIC/MOOD	
		NEUROLOGICAL		Depression	aa.
		Aphasia	t.	Manic depressive (bipolar disease)	ff.
		Cerebral palsy	s.	OTHER	
		Cerebrovascular accident (stroke)	l.	NONE OF ABOVE	rr.
I2.	<b>INFECTIONS</b>	(If none apply, CHECK the NONE OF ABOVE box)			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Clostridium difficile (c. diff.)	b.	Sexually transmitted diseases	h.
		Conjunctivitis	c.	Tuberculosis	i.
		HIV infection	d.	Urinary tract infection in last 30 days	j.
		Pneumonia	e.	Viral hepatitis	k.
		Respiratory infection	f.	Wound infection	l.
				NONE OF ABOVE	m.
I3.	<b>OTHER CURRENT DIAGNOSES AND ICD-9 CODES</b>	(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)			
		a.			
		b.			
J1.	<b>PROBLEM CONDITIONS</b>	(Check all problems present in last 7 days unless other time frame is indicated)			
		INDICATORS OF FLUID STATUS		OTHER	
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Delusions	e.
		Inability to lie flat due to shortness of breath	b.	Edema	g.
		Dehydrated; output exceeds input	c.	Fever	h.
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	Hallucinations	i.
				Internal bleeding	j.
				Recurrent lung aspirations in last 90 days	k.
				Shortness of breath	l.
				Unsteady gait	n.
				Vomiting	o.
				NONE OF ABOVE	p.
J2.	<b>PAIN SYMPTOMS</b>	(Code the highest level of pain present in the last 7 days)			
		a. FREQUENCY with which resident complains or shows evidence of pain		b. INTENSITY of pain	
		0. No pain (skip to J4)		1. Mild pain	
		1. Pain less than daily		2. Moderate pain	
		2. Pain daily		3. Times when pain is horrible or excruciating	
J4.	<b>ACCIDENTS</b>	(Check all that apply)			
		Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	Other fracture in last 180 days	d.
				NONE OF ABOVE	e.
J5.	<b>STABILITY OF CONDITIONS</b>	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)			
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem			
		End-stage disease, 6 or fewer months to live			
		NONE OF ABOVE			
K1.	<b>ORAL PROBLEMS</b>	Chewing problem			
		Swallowing problem			
		NONE OF ABOVE			
K2.	<b>HEIGHT AND WEIGHT</b>	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes			
		a. HT (in.)		b. WT (lb.)	
K3.	<b>WEIGHT CHANGE</b>	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days			
		0. No	1. Yes		
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days			
		0. No	1. Yes		



K5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days)			
	Parenteral/IV	a. On a planned weight change program			
	Feeding tube	b. NONE OF ABOVE			
	PARENTERAL OR ENTERAL INTAKE	(Skip to Section M if neither 5a nor 5b is checked)			
	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days	0. None 1. 1% to 25% 2. 26% to 50%	3. 51% to 75% 4. 76% to 100%		
	b. Code the average fluid intake per day by IV or tube in last 7 days	0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day	3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day		
M1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]		Number at Stage	
	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.				
	b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.				
	c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue.				
	d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.				
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)			
	a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue				
	b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities				
M4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT (Check all that apply during last 7 days)	Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE			
	SKIN TREATMENTS (Check all that apply during last 7 days)	Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE			
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days)	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE			
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning a. Evening b. NONE OF ABOVE			
(If resident is comatose, skip to Section O)					
N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None			
O1.	NUMBER OF EDUCATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)			
	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)			
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)			
	a. Antipsychotic		d. Hypnotic		
	b. Antianxiety		e. Diuretic		
	c. Antidepressant				
P1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days			
	TREATMENTS	Chemotherapy Dialysis IV medication Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions			
	PROGRAMS	Ventilator or respirator Alcohol/drug treatment program Alzheimer's/dementia special care unit Hospice care Pediatric unit Respite care Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) NONE OF ABOVE			
	b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note—count only post admission therapies]				
	(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days				
	a. Speech - language pathology and audiology services				
	b. Occupational therapy				
	c. Physical therapy				
	d. Respiratory therapy				
	e. Psychological therapy (by any licensed mental health professional)				
P3.	NURSING REHABILITATION RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)			
	a. Range of motion (passive)		f. Walking		
	b. Range of motion (active)		g. Dressing or grooming		
	c. Splint or brace assistance		h. Eating or swallowing		
	TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care		
	d. Bed mobility		j. Communication		
	e. Transfer		k. Other		
P4.	DEVICES AND RESTRAINTS	Use the following codes for last 7 days: 0. Not used 1. Used less than daily 2. Used daily Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising			
P7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)			
P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)			
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support			
R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:					
a. Signature of RN Assessment Coordinator (sign on above line)					
b. Date RN Assessment Coordinator signed as complete					
Month Day Year					
c. Other Signatures Title Sections Date					
d. Date					
e. Date					
f. Date					
g. Date					
h. Date					

**MINIMUM DATA SET (MDS) — VERSION 2.0**  
**FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING**  
**DISCHARGE TRACKING FORM [do not use for temporary visits home]**

**SECTION AA. IDENTIFICATION INFORMATION**

1. RESIDENT NAME <sup>⓪</sup>	a. (First) _____ b. (Middle Initial) _____ c. (Last) _____ d. (Jr/Sr) _____			
2. GENDER <sup>⓪</sup>	1. Male _____ 2. Female _____			
3. BIRTHDATE <sup>⓪</sup>	<div style="display: flex; justify-content: space-around;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>			
4. RACE/ETHNICITY <sup>⓪</sup>	1. American Indian/Alaskan Native _____ 2. Asian/Pacific Islander _____ 3. Black, not of Hispanic origin _____ 4. Hispanic _____ 5. White, not of Hispanic origin _____			
5. SOCIAL SECURITY <sup>⓪</sup> AND MEDICARE NUMBERS <sup>⓪</sup> [C in 1 <sup>st</sup> box if non med. no.]	a. Social Security Number _____ b. Medicare number (or comparable railroad insurance number) _____			
6. FACILITY PROVIDER NO. <sup>⓪</sup>	a. State No. _____ b. Federal No. _____			
7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] <sup>⓪</sup>	_____			
8. REASONS FOR ASSESSMENT	(Note—Other codes do not apply to this form) a. Primary reason for assessment _____ 6. Discharged—return not anticipated _____ 7. Discharged—return anticipated _____ 8. Discharged prior to completing initial assessment _____			
<b>SIGNATURES OF STAFF COMPLETING FORM</b>				
a. Signatures	Title	Sections	Date	
b.			Date	
c.			Date	

**SECTION R. ASSESSMENT/DISCHARGE INFORMATION**

3. DISCHARGE STATUS	a. Code for resident disposition upon discharge 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other b. Optional State Code _____
4. DISCHARGE DATE	Date of death or discharge <div style="display: flex; justify-content: space-around;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>

**SECTION AB. DEMOGRAPHIC INFORMATION**

[Complete only for stays less than 14 days] (AA8a-8)

1. DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date <div style="display: flex; justify-content: space-around;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>
2. ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

**SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION**

6. MEDICAL RECORD NO.	_____
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⓪ = Key items for computerized resident tracking

[ ] = When box blank, must enter number or letter [a, ] = When letter in box, check if condition applies

# **MINIMUM DATA SET (MDS) — VERSION 2.0** **FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING**

## **REENTRY TRACKING FORM**

### **SECTION AA. IDENTIFICATION INFORMATION**

1.	<b>RESIDENT NAME</b> <sup>⓪</sup>	<div style="display: flex; justify-content: space-between;"> <span>a. (First)</span> <span>b. (Middle Initial)</span> <span>c. (Last)</span> <span>d. (Jr/Sr)</span> </div>			
2.	<b>GENDER</b> <sup>⓪</sup>	<div style="display: flex; justify-content: space-between;"> <span>1. Male</span> <span>2. Female</span> </div>			
3.	<b>BIRTHDATE</b> <sup>⓪</sup>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>			
4.	<b>RACE/ETHNICITY</b> <sup>⓪</sup>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     1. American Indian/Alaskan Native                      2. Asian/Pacific Islander                      3. Black, not of Hispanic origin                 </div> <div style="width: 45%;">                     4. Hispanic                      5. White, not of Hispanic origin                 </div> </div>			
5.	<b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <sup>⓪</sup> [C in 1 <sup>st</sup> box if non med. no.]	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     a. Social Security Number  <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> <div style="width: 45%;">                     b. Medicare number (or comparable railroad insurance number)  <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> </div>			
6.	<b>FACILITY PROVIDER NO.</b> <sup>⓪</sup>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     a. State No.  <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> <div style="width: 45%;">                     b. Federal No.  <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div> </div>			
7.	<b>MEDICAID NO.</b> ["+" if pending, "N" if not a Medicaid recipient] <sup>⓪</sup>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>			
8.	<b>REASONS FOR ASSESSMENT</b>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     [Note—Other codes do not apply to this form]                      a. Primary reason for assessment                       9. Reentry                 </div> <div style="width: 45%;"></div> </div>			
9.	<b>SIGNATURES OF PERSONS COMPLETING FORM</b>				
	Signature	Title	Sections	Date	
b.					Date
c.					Date

### **SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION**

4a.	<b>DATE OF REENTRY</b>	Date of reentry <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
4b.	<b>ADMITTED FROM (AT REENTRY)</b>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">                     1. Private home/apt. with no home health services                      2. Private home/apt. with home health services                      3. Board and care/assisted living/group home                      4. Nursing home                      5. Acute care hospital                      6. Psychiatric hospital, MR/DD facility                      7. Rehabilitation hospital                      8. Other                 </div> <div style="width: 45%;"></div> </div>
6.	<b>MEDICAL RECORD NO.</b>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>